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Bringing Relational Comparison into Development Studies:

Global Health Volunteers' Experiences of Sierra Leone

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Abstract

Global health volunteering is premised on a comparative understanding of development: hospitals in developing countries are 'behind' modern institutions in developed nations and sharing volunteers' skills will enable the latter to 'catch-up'. We argue for a 'relational comparison' in development studies, which draws upon a geographical conception of inequality premised on understanding places in relation to one another, rather than reifying differences between countries. We place a particular hospital within a dialectical totality of combined and uneven development. Health workers' experiences of volunteering in Sierra Leone demonstrate that local problems, including staff shortages and corruption, are enveloped within global processes.

Key Words: Geography, Global Health, Relational comparison, Sierra Leone, Uneven development, Volunteering

I Introduction

‘I thought I had an appreciation of what underdeveloped was... Now I think I had no idea, to be honest, yeah. I have very clear memories of the emergency ward at the Connaught Hospital, and it was a hellhole really, I mean, it was an appalling place.’

Volunteer Doctor, Sierra Leone, mid-2010s

‘Instead of taking as given pre-existing objects, events, places and identities, I start with the question of how they are formed in relation to one another and to a larger whole.’

Gillian Hart, 2002: 14

In the opening quotation, a British doctor makes an implicit comparison between the experience of being a global health volunteer in Sierra Leone and their experiences of hospitals in the global North. Volunteers at Connaught Hospital in Freetown were faced with awful clinical conditions and an informal micro-economy. Patients that could afford to pay accessed treatment, while those that could not were – more often than not – excluded from even the most basic of medical services. For international volunteers at Connaught, these conditions were difficult to comprehend. The hospital was chronically under resourced, understaffed and beset by absenteeism and ‘ghost workers’ (Walsh and Johnson, 2018). Many Sierra Leonean nurses went unpaid and sold medicines and supplies ‘from their handbags’. Here we argue that rather than ‘taking as given’ the difference between hospitals in the global North and South we need to understand how the impoverishment of places such as Sierra Leone and inequity in their healthcare systems are formed ‘in relation to a larger whole’ (Hart, 2002).

In this article, we draw the geographer Gillian Hart’s ‘relational comparison’ into development studies to denaturalize spatial inequalities (2016). First, we set out a theoretical argument which posits that development initiatives, including global health and volunteering programs,

are underpinned by a comparative understanding of history (Crane, 2010; Griffiths, 2017). In such popular models, developing countries are deemed to be doing poorly in comparison to developed ones due to internal conditions, which present obstacles to modernization and social change (Sachs, 2005; Parsons, 1971). We argue this logic is flawed as it ignores the historical and contemporary processes via which uneven development is produced through spatial relationships (Arrighi 1994, Frank 1967; Smith, 2008), as well as the unique attributes and relations embedded in particular places (Massey 1993, Hart, 2006). Following this section, we provide a note on our primary research with 70 international volunteers and Sierra Leonean health workers. In the fourth section, we explore the experiences of volunteers who have worked across Western hospitals and Connaught. Our findings initially highlight the comparative difference, but more importantly, analysis of volunteers' experiences alongside those of their local partners, enables us to grasp some of the global-scale relations that shape healthcare in Sierra Leone.

In our conclusion we make two arguments pertinent to advancing development studies. The first is analytical. Our work furthers the geographical claims of Hart, and others across different disciplines (Chakrabatay, 2000; Comaroff and Comaroff, 2012; Harootunian, 2015; McMichael, 1990), that to understand uneven development we need to expose both the unique local social relations and global spatio-historical context in which places are situated (Massey, 1993). The second is methodological. We argue that qualitative analysis of the *experiences* of volunteers and their partners in development programmes can reveal the relations that produce inequalities, because of the unique social insights of professionals who work across diverse societies (Reid *et al.*, 2018).

II Comparisons in development theory

Comparisons are writ large across the history of international development research, from country rankings to multi-national case studies (Rist, 2014). Yet, comparing two or more places as a method for understanding social change can be deeply misleading (Hart, 2006). A fundamental error of ahistorical social science “is to reify parts of the totality into such units [e.g. nation states] and then to compare these reified structures” (Wallerstein, 1974: 388). The method of juxtaposing national societies is premised on the assumption that those places are unrelated in time and space (McMichael, 1990; Mamdani, 2018). Social change is not simply the property of individual societies, but the culmination of global processes of uneven development, the effects of which are manifested in particular places (Brooks, 2017; Smith, 2008). Simultaneous experiences of conditions of affluence or poverty in different societies are incomparable and yet interconnected. As the Marxist geographer Doreen Massey (1993: 145) argued, the ‘interdependence [of all places] and uniqueness [of individual places] can be understood as two sides of the same coin. In which two fundamental geographical concepts – uneven development and the identity of place – can be held in tension with each other and can each contribute to the explanation of the other’.

In contrast to Massey’s geographical analysis and Wallerstein’s world-historical perspective, in the Weberian field of ‘comparative history’ crude geographical comparisons helped reproduce the ‘coloniser’s model of the world’ (Blaut, 1993). Comparison thus served as a powerful tool of subjugation. Modernization models projected sequences of transitions from traditional to post-industrial societies. Traditional societies had ‘particularistic’ values with strong kinship and family ties as opposed to the ‘universalistic’ values which characterise modern societies with wider social circles (Parsons, 1971). People with histories of colonization were forced to

live comparatively in ways that consistently naturalized and hierarchized relationships (Harootunian, 2005). Deeply flawed developmental theories, such as environmental determinism deployed the socially constructed category of 'nature' as the independent variable that determined social change (Blaut, 2000). Nations were ranked in stages of development (Rostow, 1960). Non-western regions were defined in comparison to Euro-American experiences and placed on a lower tier; oriental societies were 'less-developed' and 'backward' (Comaroff and Comaroff, 2012; Said, 1979). Often a temporal dimension was applied to rationalize the comparison. Popular conceptions characterised developing countries as 10, 50 or even 100 years behind developed ones. There was a 'development gap' to be narrowed (Fukuyama, 2008). Africa, Asia and Latin America needed to 'catch-up' with Europe and North America, as if non-Western societies were sat in the waiting room of history (Chakrabatay, 2000). Their teleological journey to an ideal-type of modern society governed by Weberian Western rationalism had stalled (Blaut, 2000).

The logic of modernization bled in to policy-making (Ferguson, 1999). Colonialism had introduced technologies and modern ideas, but later another 'big-push' from the post-1945 development industry was required to help deliver 'the end of poverty' (Sachs, 2005). As Jeffery Sachs (2005: 31, emphasis added) explains: '...the real story of modern economic growth has been the ability of some regions to achieve unprecedented long-term increases in total production to levels never before seen in the world, while other regions stagnated, *at least by comparison.*' In such arguments poverty is characterized as something inherent and 'natural' resulting from environmental or traditional cultural conditions internal to poor societies. The Global South was doing badly *in comparison* to the North and needed help to achieve a Rostowian 'take-off'. What is absent from comparative analysis like Sachs' is an

awareness of the deeper relations between the developing and developed worlds and the historical processes that have produced uneven development (Smith, 2008; Unwin, 2007).

The modernization models and policy prescriptions that emanated from Europe and North America in the mid-twentieth century came under sharp criticism from dependency theorists whose work centered on Latin America. The dependentistas and their consorts including Immanuel Wallerstein (1974), Andre Gunder Frank (1967) and Walter Rodney (1972) identified systemic and potentially insurmountable differences between rich and poor countries that required historical and analytical explanation. They argued that the capitalist relations binding the centre and the periphery of the world economy generated a continual 'development of underdevelopment'. Rather than developing countries, such as Sierra Leone, being on the early steps on a teological ladder of progress, their 'underdevelopment' was a permanent condition that plagued poor regions of the global economy. Comparative advantages that were socially constructed through the colonial era had underdeveloped 'peripheral' regions of the world and drawn them into the service of core economies. These patterns of relationship were further sustained through unequal exchange (Amin, 2014) and neo-colonial political interventions in the global South (Fanon, 1963; James, 2001). For a period in the 1970s the dependentistas' radical critiques of capitalism in the periphery influenced policy making, but soon came under sustained attack. Latin America was rocked by bouts of financial instability, foreign debt crises, economic stagnation and hyperinflation. More broadly internal inconsistencies within dependency theory – including attributing agency to structure – were unpicked and it faced ideological defeat in the face of hegemonic neo-liberalism (Saad-Filho, 2005).

Although it fell from grace dependency theory did not disappear. Giovanni Arrighi – who was influenced by Immanuel Wallerstein and Andrew Gunder Frank – in his most famous work, *The*

Long Twentieth Century (1994), argues that capitalism progressed through a staggered series of steps centered on hegemonic western economic centres, from Genoa, to Amsterdam, London, and New York across the 700 hundred year history of colonial and neo-colonial capitalism. Arrighi's thesis was subsequently extended to embrace the rise of Beijing, reflecting the critical progression of East Asia as a global centre of capital accumulation (2007).

Here we take the uneven development of core and periphery as the starting point for our discussion, but we move away from the functionalism of dependency theory. To borrow again from Doreen Massey (1993) we want to understand how the unique identity of a given place can contribute to understanding combined and uneven development. In our method we take further inspiration from another geographer, Gillian Hart (2002), who like Arrighi analysed the global importance of Chinese capital in the 2000s. Hart's method was fundemenally different to Arrighi and other dependency theorists. Her analysis was built from the perspective of providing a detailed local scale understanding of the struggles in South African industrial workplaces that were managed by Chinese firms through a scholarship that explores relations across territorial and conceptual boundaries.

Gillian Hart's work, rooted in a Gramscian conception of the world, has challenged social scientists to think differently about the potential of comparison (2004; 2016). Her (2002; 2006) relational comparisons of economic inequality, nationalism, populism and racism in post-Apartheid South Africa were underpinned by critical ethnography and an analysis of the production of space and place. Through her work she deploys relational methods that contribute to revealing the 'mutually constitutive process through which metropolis and (post)colonies make and remake one another' (Hart, 2006: 981). In her relational comparative approach, Hart (2016: 3) rejects "any notion of pre-given 'cases' or variants of a presumed

universal/general process, relational comparison focuses instead on spatio-historical specificities as well as interconnections and mutually constitutive processes". She uses relational comparison as "a practical tool of analysis" (2016: 3). This entails a combined move "bringing [the] key forces at play in South Africa and other regions of the world into the same frame of analysis, as connected yet distinctively different nodes in globally interconnected historical geographies." (2016: 3) For Hart, South Africa is not passively experiencing inequality in comparison to elsewhere, but part of an interconnected whole.

Hart acknowledges a debt to Philip McMichael (1990: 389) who argued, in his ground-breaking essay on incorporating comparison within a world-historical perspective, that "the whole is discovered through analysis of the mutual conditioning of parts". Reformulating comparison so it becomes subordinate to advancing historically grounded theories of uneven development enables us to understand the effects experienced in particular places. Hart's method has helped invigorate debates in urban studies (Robinson, 2011; Ward, 2009; 2010), but has not found the same purchase in development studies. Here we seek to address this lacuna through empirical, qualitative research on international volunteering in global health. The field of medicine is marked by the prevalence of modernization programmes and comparative experiences are the *raison d'être* of development volunteering (Schech *et al.*, 2016).

Comparison in Development Practice: Global Health and Volunteering

In the health sector, development interventions have spread modern knowledge and resources from the Global North to the South. Modernization informed colonial style 'international health' and 'tropical medicine' practices, that were later re-branded as 'global health' programmes (Crane, 2010). Foremost were responses to infectious diseases such as Malaria, HIV/AIDS, Tuberculosis and the 2013-16 the West African Ebola outbreak (Herrick and

Brooks, 2018; Richards, 2016). Global health has overwhelmingly focussed on vertical (single) disease programmes to respond to these infectious disease threats and there is no doubt that such interventions have improved mortality and morbidity rates (Deaton, 2014). Yet even as global health funding, teaching and activity has boomed, a huge inequality in healthcare provision and access has remained, critically characterised as the '10/90 gap': only ten percent of global expenditure supported research and treatment of diseases that affected ninety percent of the world's population (Luchetti, 2014). Crucially and, as the West African Ebola outbreak made all too stark, global health funding and resources have not adequately responded to the overwhelming need for health systems strengthening in many countries of the global south. And, as Walsh and Johnson make clear in their recent book about the experience of Sierra Leone's healthcare system, global health vertical programming has actually had the perverse effect of creating islands of best clinical practice and provision (for AIDS, Malaria and TB) at the expense of the wider healthcare system (2018).

Global health interventions ironically depend on stark variations in the geography of healthcare provision (Crane, 2010). Global health partnership programmes are underpinned by a comparative understanding of world history and rests on a paradox: the inequality between the South and North is a form of suffering that requires redress, but also for successful institutions and global health experts, offers up opportunities for knowledge-generation and prestige. Johanna Crane (2010) explored how this paradox is exploited and has fuelled an 'industry' of competing healthcare organisations and NGOs, especially in the global health "hot spot" of sub-Saharan Africa. North American institutions, in particular, sought 'strategic advantage' through inequality: 'untreated epidemics are simultaneously envisioned as a socio-medical ill *and* [original emphasis] instrumentalized as a scientific asset by American

universities seeking to engage in “global health” activities’ (2010: 79). Global health is not just instrumentalized at the institutional scale. International volunteering has long been at the forefront of development interventions and supported health programmes (Schech *et al.*, 2015). Doctors and nurses that have volunteered to work in the global south have invariably compared their experiences in Western healthcare systems to postcolonial contexts (McLennan, 2014). For many development workers, international placements help further their careers through deploying their *comparative* experience once they return home (Craggs and Neate, 2016).

Geographical variation and inequality motivates volunteering as people from the Global North want to both *experience* difference and, for some, try to *address* these international imbalances (Griffiths, 2015; 2016). Volunteers, prior to departing overseas, draw from the well of public knowledge concerning inequalities between rich and poor nations. Ahistorical worldviews that frame social change as the property of individual societies predominate (Hickel, 2013; 2017). The history of the postcolonial world is absent from what can be characterised as “ordinary folks’ perceptions of the causes of poverty” (Patnaik, 1988: 2), or what Antonio Gramsci termed the ‘common sense’ that constitutes popular understanding (1971).

Research into volunteers’ subsequent experiences of international development placements shows that their knowledge of the causes of uneven development varies (Brown, 2015). For instance, short-term ‘voluntourists’ and gap year students may perpetuate a *common-sense* comparative historical understanding that takes inequality ‘as given’ (Hickel, 2013; Schech *et al.*, 2016). They isolate and compare ‘home’ and ‘abroad’ and explain poverty in the latter as due to inherent local conditions that make it different to the former (Griffiths, 2015). Such

volunteers can be unreliable narrators who reinforce a depoliticised understanding of unequal postcolonial geographies (Baillie Smith and Laurie, 2011). In contrast volunteers that have socially embedded experiences can transcend the inequalities between home and host societies (Griffiths and Brown, 2017). Volunteers can appreciate the ways their lives are entwined with others and recognise their socio-economic privilege within an unequal world (Lough and Oppenheim, 2017). Their experiences of multiple places can provide insights into the relations that reproduce spatial inequality as ‘...the whole is discovered through analysis of the mutual conditioning of parts’ (McMichael, 1990: 389). Taking this further, we examined the social experiences of both locals and international volunteers at Connaught Hospital to provide a relational comparison of global health. This type of relational understanding helps shed qualitative light on the global causes and consequences of inequalities.

III Fieldwork

Our study centred on King’s Health Partners programme at Connaught Hospital in Freetown. Connaught is Sierra Leone’s principal adult referral hospital, King’s is based in London and is one of Europe’s largest hospitals. The King’s Sierra Leone Partnership (KSLP) sent 87 volunteers on placements ranging from several weeks to multiple years between 2013 and 2016. Key areas of focus were in developing capacity in critical care and anaesthetics, mental health, emergency medicine, internal medicine, pharmacy and physiotherapy as well as responding to the Ebola response. KSLP won plaudits for its continued support throughout the Ebola epidemic, which helped consolidate a relationship with the Ministry of Health and Sanitation (Herrick and Brooks, 2018; KSLP, 2017).

The research involved two phases. First, we carried out interviews with 40 current or returned volunteers and international staff in 2016 (including, doctors, nurses and managers) either face to face in London or via skype; as many lived elsewhere in the UK or internationally. Secondly, in 2017 and 2018 we undertook field research in Freetown; 30 interviews, 26 with Sierra Leoneans (doctors, medical students, nurses, support staff) and four with volunteers and international staff, and six ward visits. As we have explored elsewhere, engaging Sierra Leoneans in research was challenging (Herrick and Brooks, 2018). Local nurses and doctors tended to work second jobs to supplement their incomes and had little free time for interviews. Furthermore, Sierra Leoneans were relatively closed in their answers and some expressed ‘interview fatigue’ as they had been repeatedly engaged in research following the Ebola epidemic (Richards, 2016), and as Connaught has become increasingly saturated as a global health research site. In contrast, providing a narrative of cross-cultural experiences was something of a cathartic exercise for expatriate volunteers keen to reflect on what they had seen and learnt. This openness facilitated the interviews (Cunningham *et al.*, 2017). To illustrate our relational comparison, we made extensive use of anonymised quotations from the international volunteers, labelled L (London). Supporting quotes from Sierra Leoneans, are labelled SL. Our shared institutional affiliation facilitated field visits, access to documents, provided practical support and enabled interviews. However, this article is not intended as an appraisal of the success or otherwise of KSLP, and the findings and analysis are independent.

Healthcare at Connaught Hospital, like most of Sierra Leone, was exceptionally poor when KSLP was inaugurated in 2011 (Walsh and Johnson, 2018; Thomas, 2016; WHO, 2015). Such a judgement is corroborated in international data. In 2013 Sierra Leone was among the poorest countries in the world, it ranked 183rd out of 187 nations in the Human Development Index

(HDI). Life expectancy was 50.7 years for women and 47.6 for men, and there were just two physicians per 100,000 people. Mortality for under-fives was the worst in the world: 182 per 1,000 live births (UNDP, 2014). The combination of first-hand observations, interviews and published data provides compelling evidence that the Sierra Leonean health service fared terribly in international comparisons. While such basic observations are accurate, they are also deeply problematic and ahistorical. In our relational comparison of global health, we use the volunteers' experiences of hospitals in the Global North to pose questions of Connaught. Differences in places be they hospitals, cities, or nation states have to be theorized as open, embedded and relational (Ward, 2010). Therefore, our analysis does not reify the Sierra Leonean experience, but seeks to understand it within a global perspective that exposes some of the relations that reproduce poverty.

Our field research highlighted social phenomena that are challenging to understand, this includes theft and corruption among local healthcare workers. To paint such acts as models of petty self-interest characteristic of less-developed health systems and traditional societies, is to fall back on historical comparison as the explanation. Instead in our method we brought the key relational forces that were at play in Sierra Leone and internationally into the same frame of analysis. Sierra Leone's legacy of colonisation and conflict as well as decades of donor support and migration have structured its relationship with the global economy (Bayart, 1993; Harris, 2013; Rodney, 1972). Such connected yet distinctively different relationships were nodes in the production of global processes, rather than Sierra Leoneans being solely culpable for conditions at Connaught Hospital.

IV Connaught Hospital in comparison

For many KSLP volunteers the abject poverty of Sierra Leone was a new experience. Gender inequality, low education levels and weak infrastructure inhibited healthcare training and delivery at Connaught Hospital. Encouraging people to learn was difficult 'because their environment was so awful' [L18]. People were 'dying all the time of stuff they shouldn't die of' [L28]. Volunteers put this in comparative perspective. One example given, among many, was an anaemic 13-year-old girl who died because she did not get a blood transfusion 'something that is the bread and butter of what happens in the UK and we would never allow to happen' [L24]. International volunteers with experiences elsewhere in the Global South including Afghanistan, Tanzania and Uganda judged healthcare in Sierra Leone to be worse. Resources at Connaught Hospital were 'behind Haiti' [L13] and this included both treatment facilities and the capacity of local staff to perform medicine.

Volunteers made temporal as well as spatial comparisons, further contributing to a narrative of historicism. For instance, a physician recalled observing a whole chest cavity full of fluid 'it almost took me back, because I trained 25 years ago... But you never really see them in Western countries now... its little bit like going back in time as well.' [L12] A *common sense* comparative understanding of Connaught Hospital falsely characterised it as 'behind' other places. To progress to relational comparison, we needed to consider the political and economic relations that underpinned the difference in the contemporary. Here we focus on three areas: hospital facilities, staff capacity and marketization.

Hospital Facilities

The hospital received a limited budget from the Ministry and lacked many of the essential facilities needed to provide basic care and ensure infection control. Sierra Leoneans made comparisons to healthcare elsewhere: ‘we are far behind in terms of light [electricity]. Of course, a typical hospital should have 24-hour light... we see a lot of people dying because of light who are in the ICU [intensive Care Unit] department.’ [SL12]. Surgery was sometimes performed in emergencies by the light from a mobile phone. There were wards: ‘without the basic things to take vitals; the SpO2 [pulse oximeter], the blood pressure machine’ [SL6]. As for water ‘there was no running water from the taps at Connaught, so we managed to get buckets of water where they have a tap.’ [L23].

State spending on healthcare in Sierra Leone was US\$224 per capita in 2014 (WHO 2017). The national government was indebted, revenues were low and variable, and macro-economic performance was dictated by relationships with the world economy. Sierra Leonean policy-makers had only limited influence over the activities of donor agencies and international investors (Allouche, 2014), many of whom had donated to Connaught or undertaken renovation and rebuilding in a piecemeal way. Decisions made regarding Connaught Hospital were made across a complex variety of geographic and governance scales – from doctors, to hospital management, to the Ministries of Health and Finance, all the way up to the President’s Office, and the local and international donor community. Connaught was enmeshed within a globalised arrangement of donor support and governance initiatives, many of which were uncoordinated by the Ministry. But there were efforts to try and rectify this in 2015 when development aid was top-sliced by 5% by the government as part of efforts to get to grips with the newly increased flows of Ebola funds into the country.

Like many African hospitals, Connaught frequently received unsolicited donations from development agencies and private donors, but the technologies were often inappropriate. Machines were supplied without support for maintenance and training. For example, 'there was a dialysis unit, people were trying to get a dialysis unit in a hospital that had no running water' [L4]. Inappropriate and unsustainable attempts to modernise health systems have long been critiqued in development literature for forging dependency (Easterly, 2013). The result was a graveyard of unusable equipment in the hospital (without any system for waste disposal), a phenomenon that has been noted in other African contexts (see Wendland, 2016 on Malawi). Relations reproduced through patterns of assistance rooted in personal connections primarily satisfied the individual donor (Griffiths, 2015). As a Volunteer cynically observed: 'I think it's very easy to just turn up, donate a piece of equipment, have your picture taken, stick it on Facebook, leave, and feel very good about it' [L21].

A priority that local staff and KSLP agreed upon was oxygen delivery. A Volunteer found the situation inconceivable: 'In every bed in the UK you'll find an oxygen port, and this was set aside for four beds in the ICU' [L28]. KSLP facilitated the provision of oxygen which transformed care, as the same Volunteer elaborated: 'Any changes that I'm making are potentially, you know 0.01%, which is still important, whereas with the oxygen we reduced mortality from 50% of admissions to 30%.' The hospital had had an oxygen factory before the civil war. This fact is important and provides an example of the fallacy of historicism that permeates comparison. In *common sense* comparison, teleological narratives prevail, which posit that development interventions can help hospitals ratchet-forward and progress through the introduction of modern technologies. In reality, the absence of oxygen provision at Connaught in 2013 was an indicator that conditions had actually deteriorated. Social progress is rarely linear in the

straight forward manner presumed in models of modernization, such as Rostow (1960). In contrast, the non-linear nature of social progress was also emphasised by the dependenistas.

Staff capacity

The level of the hospital's human resourcing had also deteriorated. There was a 'missing generation of healthcare workers' [L28] in Sierra Leone as many left or were killed during the civil war. For example, there were only two anaesthetists in the country and both were 63 years old. The conflict was exasperated by Sierra Leone's relations with the wider world, including deteriorating terms of trade and the effects of IMF and World Bank structural adjustment programmes (Zack-Williams, 2010). During the war salaries went unpaid and the staff that remained at Connaught found other ways to make a living. Doctors set up private clinics and nurses treated paying patients in their communities. Informal work was financially rewarding, which detracted staff from their official duties. This practice became ubiquitous as delayed and reduced salaries continued to affect all workers. In 2016-17 hospital consultants went at least five months without getting paid. These factors did little to ensure healthworker retention and out-migration of trained doctors and nurses continued apace in Sierra Leone.

The Hospital reportedly had 1,200 staff, of which only 700 were on the pay roll (Thomas, 2016). The rest were unsalaried volunteer Sierra Leoneans who provided nursing care '...almost 80% of the workers here in the hospital, they have been volunteers which have not been paid for the last four years...' [SL22]. The discrepancy between the hospital's figures and the observed percentage of local volunteer nurses was explained by absenteeism. 'Ghost workers' were a drain on resources: 'There's various estimates of how many people are drawing down a salary whom never actually show up, or just come in for an hour or two to sign a timesheet' [L30]. Local nurses work voluntarily both in the hope of getting a permanent salaried job and to sell

medicines and services to patients, discussed below. The Ministry is unable to appoint sufficient staff and those that do get salaried positions do so through political connections or 'corrupt payments'. There were tensions between Sierra Leonean volunteers and the senior salaried nurses: '...they see me sitting with my salary, my money in my hands, they are soon discouraged.' [SL22]. Motivation was difficult as some unsalaried nurses struggled to afford to eat lunch or take 'teas', which left them debilitated.

Connaught Hospital was operating with a few senior consultants and some clinical health officers and senior staff nurses '...to try and run a service which, on paper, was like that of any other teaching hospital with a handful of physicians was totally unrealistic.' [L32]. Working under these conditions had a debilitating and demoralising effect on Sierra Leonean clinicians, some of whom 'their anatomy knowledge and technical skills were fantastic, it's just all the other supporting elements that need work.' [L35]. As a volunteer doctor described: 'one of the surgical doctors is trained to an incredibly high standard, he knows what's good. Professor X exactly the same. Yet they both can work in and tolerate standards that they know are not high enough.' [L24] The care provided at Connaught was not limited by the abilities of the senior Sierra Leonean medical professionals, but constrained by the working conditions, including a lack of resources, insufficient staff and low pay. The same volunteer recognised the pressures under which Sierra Leoneans worked: 'So I think [if] you can eke out even the littlest corners of quality, that's the most amazing outcome.' This finding supports research elsewhere that argues African medicine is not 'behind' that of the North, but rather relies on forms of creativity and improvisation in response to low resources (Livingston, 2012).

Trainee doctors wanted experience overseas and nurses were eager to learn directly from King's Health Partners in London: 'I want to go there to do any courses for one month, two

months, any course.’ [SL23]. However, the systemic, relational problem associated with overseas training was that it fed emigration and perpetuated the country’s existing skills shortages: ‘If you let people go somewhere for five years while they do that they’re not really interested in coming back at the end of it.’ [L35]. An estimated 60% of trained nurses emigrate: ‘Lots of them want to go to the UK. A fair degree, Canada... And the US. But some will go to Ghana.’ [L16]. Emigration provides one of the starkest illustrations of the importance of understanding the hospital’s challenges from a relational perspective. Migration to the UK was indicative, 347 Sierra Leonean professional clinical staff worked in the NHS (National Health Service) in 2014 (Chalabi, 2014) and 511 (clinical and non-clinical) in 2017 (House of Commons Library, 2017). Sierra Leonean nurses were additionally employed by nursing agencies and in social care. Sierra Leonean employment in the UK was significant relative to the total public health workforce in Sierra Leone, which was 8,125 in 2010 (the most recent available figures) (AHO, 2017). There is uncertainty over the precise scale of net emigration, but it is clear that Sierra Leone’s relationship with the wider world as a source of skilled migrants was important in diminishing staff capacity at Connaught. The contribution of Africa’s ‘medical brain drain’ to uneven geographical development is well documented (Johnson, 2005).

Marketization

The local political economy of healthcare was co-produced by Sierra Leone’s relationship with international partners (Abdullah and Rashid, 2017). State policy was orientated towards the priorities of external agencies: ‘The government are always manoeuvring to align themselves along streams of revenue’ [L8], which included mining, a nascent tourism sector and new investment from China, in addition to donor support (Africa Confidential, 2016). Meeting the demands of donors was enervating. One medic recalled a conversation with a local healthcare

leader 'he said to us one time, "you want us to develop and we're trying to survive".' [L31]. Global-scale relations, as well as national circumstances shaped healthcare, rather than Sierra Leone failing in isolation.

International development agencies were influential in promoting a culture of marketization. The most able health workers were 'drawn towards the development sector' [L7]. For example, an NGO recruited promising medics, helping their individual careers, but undermining the societal need for trained surgeons 'they appointed four trainees, three of whom were working on one of the vaccine trials and they were getting paid in a month there more than a year's salary for their surgical jobs' [L37]. Market forces structured social relations at Connaught: '...the board are continuously looking for sources of revenue. It introduces a market perspective into the hospital... NGOs are seen as for financial gain.' [L7]. Rather than Sierra Leone being *behind* in comparison to the West marketization, a flawed neoliberal solution to healthcare challenges, was more present in Freetown. This was surprising for volunteers from the NHS: 'I just mean that the hospital itself runs, in itself it's just like a big business' [L39].

Conditions of care at Connaught were dictated by how much people could afford. Destitute patients, children, Ebola survivors, pregnant women and lactating mothers were supposed to get free treatment, but they could not access most medicines. Sometimes this was due to a lack of supply '...with hepatitis, the drugs are not available' [SL22]. With other treatments the resources, such as IV fluids were available, yet unaffordable for the poor. There was a micro-economy within the hospital that determined the provision of vital care: 'So, if they cannot afford to get it [treatment], the next day they will die.' [SL29]. Almost all services required the payment of unofficial and official fees at every step of the care pathway. Some donor support improved service provision (e.g. HIV/AIDS), but also amplified opportunities for profiteering. A

donated blood sugar metre supplied an income for the operator who charged patients. Elsewhere in the hospital ‘...if you want a CT scan, you just go to the guy who runs it. Give him 100 quid [Pounds sterling] and then they do it. And if you want it quicker, if someone comes in and wants it quicker, they give them 150 quid to get in first.’ [L24].

There were ‘problems of supplies and compliance’ [SL17] including the theft and re-sale of medicines. One volunteer found thefts alarming ‘... you put this equipment in and then various people associated with the hospital will steal the equipment, they’ll take it right back out. They’ll take flushing mechanisms out of the toilets and sell them. All these things are saleable on the African market’ [L27]. Moving beyond his implicit comparison between Africa and the West, other volunteers discussed the social relations and micro-economy that supported such behaviour: ‘So we might understand a lot of it as corruption, but a lot of it is about demand from your dependents, if you like’ [L17] and ‘...when you don’t get paid for six months at a time you have to feed your family, I can’t blame someone for generating an income on the side.’ [L13].

An informal system of nursing care and medication distribution had developed. Unsalaries volunteer nurses drew an income from patients:

...you often find nurses selling drugs to the patients on the wards, directly from their handbags or from cupboard. And, you know, everybody kind [of] agrees that this shouldn’t happen that it’s the law that it should not happen. And sometimes that behaviour is accompanied with threats to patients. I mean “if you don’t buy it from me I won’t give you your medication” ... on the outset of that I was like oh that’s so bad... And then I think as you delve deeper you start to realise that a lot of the nurses are not paid so their only way of getting an income is by having these sorts of businesses on the side. And then you start to realise that the pharmacies don’t have the stock that’s needed or patients need the cheapest drugs and the nurses can sell it far cheaper. So, you start to realise that a problem like a law enforcement issue is actually far more complicated and complex to address than you might initially see.’ [L31]

When compared to Western practices the volunteer initially considered informal sales of medicines to be abhorrent, but once they understood the relations that led local nurses to act in this way their judgement shifted. They progressed, from a 'common sense' comparison to a relational comparison, they contextualised the micro-economy of the hospital by discussing the conditions that dictated local staff behaviour. Furthermore, there were examples of altruism among Sierra Leonean staff: '...they've all used their own money to pay for medicines for patients to try and keep them stable and keep them on medication...' [L3]. Sierra Leonean nurses were not 'bad' because they were part of a hospital that required modernisation, but due to the broader political economy of medical supply.

V Conclusion: Relational Comparisons in Development Studies

Spatial and historical comparisons rest upon an understanding of world history that explains social change as the result of conditions internal to specific societies (Blaut, 1993; McMichael, 1990; Wallerstein, 1974). For example the so-called 'particularistic' values associated with societies such as Sierra Leonean that have been characterised as 'traditional', could be used to explain the importance of health workers' family obligations in stimulating an informal economy of medication sales (Parsons, 1971). These values are not shared by international volunteers raised in societies with 'universalistic' values. Such comparisons are intuitive approaches to rationalizing inequalities. These worldviews have permeated popular approaches to uneven development (Sachs, 2005), yet fail to explain differences (Hickel, 2003; 1017).

Global health partnerships and international volunteering draw upon reifications of spatial differences, which take the high-standards of western hospitals located in rich developed nations to be an outcome of conditions internal to these societies. Global health promotes western models of care as the apex of development (Crane, 2010) and renders international volunteers privileged, skilled professionals able to share their knowledge (Griffiths, 2017). However, world-class hospitals in the west and the expert staff who work in them are not isolated from the wider world. They benefit from the structural inequalities of the global economy and a long history of combined and uneven development, not least when it comes to the recruitment of much-needed health workers from the global south (Johnson, 2005; Smith, 2008). They are interconnected to global flows of migration, and draw upon resources, medicines and scientific discoveries produced around the world.

These geographical relations are essential to appreciate and such patterns were brought to light by early work on the development of underdevelopment (Frank, 1967; Rodney, 1972). Since the halcyon days of the dependistas shaping policy in Latin America, dependency theory has fallen from grace and faced criticism from the political left and right (Saad-Filho, 2005). The geography of the world economy has become more complex and multi-polar (Sidaway, 2012). The relatively rigid division between core and periphery is a polarity that now provides the beginning of our analysis rather than its end (Connell, 2007). Detailed empirical field research is required to investigate the constantly changing flows that connect and make diverse places of poverty and prosperity. As Hart (2004: 91, original emphasis) forcefully argues we need to grapple 'with persistently diverse but increasingly *interconnected* trajectories of sociospatial change in different parts of the world.' This context leads us to our particular two-fold conclusions drawn by placing the situation in a specific Sierra Leonean hospital within a

dialectical totality of uneven development. The first conclusion is analytical and the second methodological.

First, through relational comparison we have avoided the pitfall of comparison and demonstrated that the social relations and spatio-historical context in which Connaught Hospital operated constrained the delivery of good healthcare. Proximate factors such as corruption, staff capacity, and resources were the ultimate outcome of these deep-rooted relationships (Harris, 2013; Zack-Williams, 2010). These relations were not formed in either Connaught, Freetown, Sierra Leone or Africa alone. The global production of spatial inequality is both a historical and continual process (Hart, 2016; Massey, 1993). Capitalist social relations perpetuate uneven development (Smith, 2008). Our research with volunteers showed that development agencies fostered market forces in Connaught Hospital, part of a long-running and broad process through which marketization was promoted in Africa by the World Bank and other financial institutions (Obstfeld, 1998). This relational aspect is also brought home in the way that many volunteers said how similar some of the problems in Sierra Leone were to the market pressures they faced working in the Global North, principally the NHS.

However, there are social relations, which evolved from shared histories. This was most clearly demonstrated through the emigration of Sierra Leonean healthcare workers (Johnson, 2005). The same inequality in global health that leads to Africa's brain drain stimulates volunteers, universities and international agencies to seek strategic advantage in spatial differences (Crane, 2010; 2011; McLennan, 2014). As a member of KSLP staff astutely observed: 'I mean, at its most basic it's a question of do they need us more than we need them? And to some extent the international development community needs countries like Sierra Leone to justify

their existence.’ [L30]. It is important to note that healthcare staffing has seen marked improvements at Connught since 2016, with a new cadre of trained doctors joining the hospital, a large-scale Ministry audit taking ghost workers off the payroll, new World Bank-funded doctors from Nigeria and a definitive uptick in staff morale and professionalised working practices.

Our second methodological finding concerns the research benefits for development studies of analysing volunteers’ and their partners’ experiences through relational comparison. Transnational social experiences can animate the uniqueness of place, but also illustrate how local process are enveloped within global uneven development (Massey, 1993; Reid *et al.* 2018). Our research demonstrated that participants initially made *common sense* comparisons between healthcare systems in Sierra Leone and the West, for example in their initial outrage towards local nurses’ informal drug sales. Yet often they themselves found that straightforward spatial and historical comparisons were unhelpful and the longer they stayed in Freetown, the more nuanced their relational understanding of the conditions at Connaught become. The socially embedded knowledge of long-term volunteers did not empower them to resolve the challenges of healthcare in Sierra Leone. Whereas new volunteers arrive excited, energised and outraged at the injustices, long-term volunteers become frustrated by these inexperienced international colleagues who thought they could change deep rooted practices. Long-term volunteers made fewer negative comparisons to healthcare in the UK or elsewhere and began accepting the differences while making incremental improvements within this specific place.

One of the most valuable conclusions that can be drawn from studying volunteer-led healthcare programmes is that an analysis of their transnational experiences can shed light on

some of the relations that reproduce poverty in the Global South. Doing research on volunteers provides a method for producing the type of relational comparison that explains poverty in specific places as part of a larger whole (Brown, 2015; Hart, 2002). Volunteering may not resolve the problems of global health inequalities but the experiences of volunteers can provide evidence to advocate for systemic change at a global scale.

Word Count: 8616

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